American Medical Association
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Roadmaps for Clinical Practice

Case Studies in Disease Prevention and Health Promotion

Intimate Partner Violence

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Preface

There is a general misunderstanding about what type of connection exists between medicine and public health practices. Most individuals, those who work in these professions and those who don't, believe that there is, in fact, little relationship…that the two—much like oil and water—just don't mix.

That belief, though still quite prevalent, is slowly changing. People are becoming more aware that each science is equally critical to the well being of both individuals and the general public. Developing a stronger partnership between the two, then, is a logical next step, as integrating prevention and treatment is increasingly imperative to progress. Significantly, decision makers are beginning to acknowledge this trend and take action.

Two of these individuals are David Satcher, MD, PhD, former US Surgeon General, and Randolph D. Smoak, Jr., MD, immediate past president of the American Medical Association (AMA). Under their stewardship, the AMA and the US Department of Health and Human Services (HHS) signed an agreement that exemplifies both organizations' commitment to a new partnership, one that focuses on helping people live healthier, longer.

This first-ever joint effort is indeed a strong indicator on behalf of these new partners, evidence that each supports the proliferation of teamwork across both professions for the sake of a healthy future. The two organizations are in the process of developing programs that directly support their new venture.

Because medical professionals are typically removed from public health activities, the AMA has prepared several resources designed to introduce and guide physicians through modern population health practices. This, in turn, will help medical professionals to enhance the traditional treatment-focused system to include prevention. *Case Studies in Disease Prevention and Health Promotion: Intimate Partner Violence* is the first in a series of many health-focused monographs developed by the AMA's Unit of Medicine and Public Health under a new program entitled *Roadmaps for Clinical Practice.* Another publication in the *Roadmaps* program, *A Primer on Population-Based Medicine,* was released in early 2002. The monograph series concentrates on the *Healthy People 2010* objectives, which were developed by the US Public Health Service, to define and help individuals address the most significant health challenges faced by our nation.

This monograph deals with violence, which has an all too clear impact on our collective health and well being. The monograph focuses on one of the most preventable types of violence, intimate partner violence, which affects not only those who suffer the physical injuries, but those who witness acts of violence between these partners—quite often children—and thus learn to regard violence as appropriate behavior.

The upcoming *Case Studies in Disease Prevention and Health Promotion* series installments will continue to zero in on the *Healthy People 2010:* 10 Leading Health Indicators, which include such prominent foci as overweight and obesity, physical activity, tobacco use, and immunization. Each volume will provide physicians with instruction on how to identify problems, and how to take action by treating to prevent.

Physicians are without a doubt the cornerstones of a healthy public. When they actively participate in prevention, public health, and awareness, they contribute unmatched expertise to health efforts in general. Join the AMA and the HHS on their journey through this comprehensive, combined health initiative; use these *Roadmaps* tools to help people. Take action—create a better future for patients and their communities.

June 13, 2002

American Medical Association
Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610

January 16, 2002

Dear Reader:

In December 2000, the American Medical Association (AMA) signed an historic agreement with the Department of Health and Human Services (DHHS) committing our organizations to work together to implement the Healthy People 2010 objectives and, thereby, reduce disparities in health outcomes. The opportunities for enacting change through American medicine are great. Our physicians provide clinical preventive services, serve as part of the public health safety net, participate in community preventive interventions, and offer their time as advocates for policy development. Clearly, however, there is much that needs to be done to help re-focus health priorities on prevention. This is especially true regarding the effort to reduce disparities in health outcomes.

There is no straightforward, simple solution to reducing health disparities. Some of the problem is caused by financial and social inequities that affect early biological development. Some of the problem is caused by inequities in access to health care. Some result from cultural and language diversity. As each person and organization defines our role in reducing health disparity, we must be careful to identify clearly what aspect of the problem we will address, and not become overwhelmed by the enormity of the causes.

The AMA will be working within organized medicine and the public health community to help bridge gaps in the science and practice of medicine and public health. We will focus on the role of low health literacy, application of disease prevention and health promotion within clinical practice, and applying principles of population-based medicine. Our new monograph series, of which this is the first issue, will use case studies in order to demonstrate how physicians can apply these three concepts to address health disparity. In addition, the AMA will work hard to implement our new national initiative to ensure access to health care for all people.

I look forward to working with HHS, and our other medical and public health partners, on achieving the goals of our memorandum of understanding. Together we can make a difference.

Sincerely,

Randolph D. Smoak Jr.

Randolph D. Smoak, Jr., MD
Immediate Past President
American Medical Association

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Surgeon General
Rockville MD 20857

January 16, 2002

Dear Readers:

In December 2000, the American Medical Association (AMA) and the U.S. Department of Health and Human Services (HHS) signed an historic Memorandum of Understanding reflecting the common commitment of the AMA and HHS to address the leading public health challenges facing the United States. This Memorandum of Understanding is built around *Healthy People 2010,* our nation's comprehensive set of national health objectives. *Healthy People 2010* has two overarching goals: to increase the years and quality of healthy life and to eliminate racial and ethnic disparities in health.

While *Healthy People 2010* was released by the Federal Government, it reflects input from clinicians and scientists from across the country, as well as from other concerned citizens. With 467 specific objectives to achieve by the year 2010, *Healthy People 2010* is the most comprehensive set of objectives that has been released since this process began in 1980. *Healthy People 2010* is also unique in that it includes a set of 10 Leading Health Indicators. These ten indicators represent high priority areas where our nation must make progress over the next decade to achieve our public health potential. The Leading Health Indicators are:

Lifestyle	**Health System**
Physical Activity	Mental Health
Overweight and Obesity	Injury and Violence
Tobacco Use	Environmental Quality
Substance Abuse	Immunization
Responsible Sexual Behavior	Access to Health Care

The AMA and HHS share common priorities and interests in *Healthy People 2010* and in the Leading Health Indicators. I commend the AMA for their dedication to improving the health of all communities and hope that our partnership will continue to be a successful one.

An outgrowth of this *Healthy People 2010* partnership is the development of a series of monographs titled "Road Maps for Clinical Practice: Case Studies in Disease Prevention and Health Promotion." The monographs are essential steps to increase your awareness of *Healthy People 2010* and the Leading Health Indicators.

It is my great pleasure to introduce you to the first of the series. The monograph is dedicated to the role of both health care professionals and public health professionals in eliminating and preventing intimate partner violence in the United States. Subsequent monographs will focus on other aspects of the Leading Health Indicators. We must get serious about improving the health of the nation by affirming our commitment to help individuals and communities target actions to improve health and access to healthcare.

We hope that you will be able to take the suggestions presented in this and future monographs and use them in your communities. The challenge that lies ahead is formidable, but one that we must address. We cannot change the past, but we can shape a different future. Let's create tomorrow's healthier people today.

Thank you for your commitment to improve the health of the people of this country and the world.

David Satcher, M.D., Ph.D.
Surgeon General
U.S. Public Health Service

Summary action plan for acute management of an abusive event

Each of the following elements should be addressed and documented in any encounter where intimate partner violence is first suspected or confirmed:

- **Chief complaint** Use the patient's own words whenever possible. "My husband broke my arm with a baseball bat" is preferable to "Patient has been abused."
- **History of present illness/injury** Again, try to use the patient's own words whenever possible. Include a description of the abusive event, an account of the injuries, what precipitated the events, when and where they took place, and who was present. It is also useful to document whether this has occurred in the past.
- **Past medical history/past surgical history** It is important to include past injuries, along with the dates on which they occurred. The patient's explanation may be included in parentheses; for example, "May 2001, cigarette burn on right forearm, treated in this ED. ('My girlfriend burned me with her cigarette.')"
- **Review of systems** Be alert to any suspicious or unexplained complaints, including weight change, fatigue, trauma, appetite change, stomach pain, history of pregnancy complications, depression, and anxiety disorder. While none of these are specific for intimate partner violence, a constellation of these may alert you to abuse.
- **Medications** If abuse is suspected, asking the patient about his/her medications may help confirm your suspicion. For example, use of antidepressants or anxiolytics and noncompliance with medication regimens may be consistent with, although not specific for, abuse. Likewise, if the patient states that he/she is not allowed to obtain or take medications, this should raise your level of suspicion.
- **Social history** Ask the patient about marital status, length of the relationship, presence of children in the home, number of people in the household, profession of the patient and abuser, history of alcohol or drug abuse in the patient and abuser, presence of firearms in the household, and available social support.
- **Physical exam** (1) General: Does the patient appear fearful, withdrawn, or tearful? Does the patient avoid eye contact? (2) Physical findings: Provide a detailed description of the injuries, including type, size, number, and location. If possible, record the location and nature of the injuries on a body chart or drawing. (3) Obtain color photographs, imaging studies, and results of pertinent laboratory or other diagnostic procedures, if applicable.
- **Assessment** In your opinion, did the patient adequately explain the injuries? Why or why not? Does your patient have a long history of ER or clinic visits for poorly explained complaints? Do you suspect or does the patient confirm intimate partner violence?
- **Plan** If your state requires physicians to report certain injuries to law enforcement officials, discuss this with the patient and make the necessary report with his/her knowledge. If the police are called, record the name or badge number of the investigating officer and any action taken. Document any other interventions that were performed (eg, safety planning, distribution of resource materials, etc.).

Introduction

This document is intended to raise physicians' awareness of intimate partner violence, and provide information on caring for patients who are its victims. Virtually every physician who treats adolescents or adults will encounter patients who have been victimized by their intimates: current or former spouses, boyfriends, or girlfriends, whether in opposite- or same-sex relationships. Neither cohabitation nor current or past sexual activity are a necessary part of the dynamics of intimate partner violence.

This document will:

- Familiarize physicians with the magnitude of the problem
- Describe how to identify abuse and violence through routine screening and recognition of clinical presentations
- Help physicians assess the impact of abuse and violence on the health and well-being of their patients
- Provide examples of questions that can elicit meaningful responses and encourage patients to explore their options and ultimately take action
- Provide information on appropriate resources for referral
- Address frequently encountered obstacles

Upon encountering an acute situation (such as the one depicted in the following case study), physicians may wish to refer to the action plan checklist on the previous page for guidance on what to include in the History and Physical. The Clinical Evaluation section of this document (see page 10) will provide additional information on performing the History and Physical, and discuss resources and interventions for the patient.

Case study

Chief complaint "I want some sleeping pills because I can't sleep at night."

History of present illness Sarah H is a 25-year-old female with no significant past medical history, who presents with insomnia. Sarah claims that she never had any problems with sleep until three months ago, when she began experiencing problems falling asleep, fitful sleep, and early morning awakening. Since the onset of her sleep disturbance, it has gradually worsened to the point that, "I don't get more than three or four hours of sleep a night." Her sleep is disturbed every night, and although she tries to take naps during the day to alleviate her exhaustion, she is unable to fall asleep.

Sarah denies any precipitating episodes, and states that she does not know why she is having sleep problems. She denies any illness during the past three months.

Past medical history Unremarkable.

Review of systems Sarah has lost 15 pounds in the past three months due to decreased appetite. She denies feeling depressed or anxious.

Medications No prescription medications. One multivitamin tab po QD.

Social history Sarah is a homemaker. She denies alcohol, tobacco, and drug use. She does not exercise regularly ("I don't leave the house much"), and states that she ate, "Whatever my husband brought home," prior to her sleep disturbances, since which time she has had very little appetite. Sarah has been married for two years to John, a 28-year-old computer engineer who was recently laid off from work. This is a first marriage for Sarah; the second for John. They have no children, and they live alone. Sarah has no relatives in the area.

Family history No history of depression on maternal or paternal side. Family history otherwise noncontributory.

Physical examination Sarah is a pale, thin woman who appears older than her stated age. Throughout the interview and exam, she is withdrawn, speaks in a quiet, hesitant voice, and does not make eye contact. Her vital signs are within normal limits. The remainder of the physical exam is within normal limits. Notably, she has no bruises or other signs of trauma.

Additional information When it is explained that sleep and appetite disturbances are common in depression, and Sarah is further questioned about other signs of depression (anhedonia, energy level, etc.), she admits that her relationship with her husband is not going well. Shortly after their marriage, John began acting possessive, and refused to allow Sarah to see her old friends or leave home on her own. In addition, he disconnected the phone in their home (he uses a cell phone) and deprived Sarah of money. Ever since he was laid off from work, John has spent most of his time at home, drinking heavily, insulting Sarah, and refusing to allow her to leave the home. Sarah was only able to come to the clinic because some of John's friends invited him to a baseball game.

This is not an uncommon situation for physicians. A patient presents with a nonspecific complaint; however, upon inquiry, intimate partner violence is disclosed, or the truth is discerned by the physician (or a member of the staff). In these situations, the physician can best provide care for his/her patient by:

- Being aware of the warning signs of intimate partner violence
- Offering the patient support and reassurance that he/she is not to blame for the abuse
- Performing a thorough History and Physical, and documenting all evidence appropriately
- Properly documenting the patient's complaints, particularly the nature and extent of injuries. In addition, the physician should consider helping to establish a safety plan with the patient. In all cases, the physician should avoid judgement about the patient's decision to either stay with or leave the abusive partner
- Offering the patient information on organizations that provide support or aid, *only if it is safe for the patient to possess these materials**
- Encouraging the patient to leave a "paper trail" by going to the ED or clinic after each episode of physical abuse, so that documentation exists if the patient ever wishes to take legal action
- Encouraging the patient to follow up at each subsequent ED or clinic visit to ensure that the patient is not currently in imminent danger, and to encourage the patient to take action against the abuser

The strategy for patient care outlined above will be presented in detail and with additional practical information in the Clinical Evaluation section of this document (see page 10).

The Clinical Evaluation section also features ways in which physicians can help to prevent further violence and abuse for patients who have already been diagnosed as victims of abuse. Of equal importance is the role that physicians can play 'upstream' as part of multidisciplinary efforts aimed at the primary prevention of intimate partner violence.

Primary prevention of intimate partner violence requires a coordinated, community-based response designed to change the norms, attitudes, behaviors, and social

* Be aware that if the patient's abuser finds such materials in the patient's possession, this could instigate further acts of violence.

conditions that lead to or condone violent behavior. Physicians can support these efforts by participating in and/or advocating for the following:

- public education and media campaigns that promote an intolerance for violence
- parenting education that promotes positive, non-violent parenting skills
- elementary school-based education programs that promote the healthy and non-violent development of children
- efforts that reduce children's exposure to violence in the media and in their communities
- educational programs for all age groups that teach non-violent conflict resolution skills, and fairness and respect in dealing with others, regardless of gender, age, family status, race, ethnicity, sexual orientation, etc.
- positive media images, education, and counseling programs that help teens develop healthy, non-violent attitudes about interpersonal relationships, sexuality, and parenting
- educational efforts and programs that break the links between masculinity and violence, and between sex and violence

Physicians play a crucial role in primary prevention efforts designed to put an end to the cycle of intimate partner violence.

Background and scope of intimate partner violence

Intimate partner violence is characterized as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and/or intimidation. Regardless of the specific behaviors, the intent of intimate partner violence is for one partner to exert power and control over the other.

Characteristics of Intimate Partner Violence	
Physical abuse	
• Hits	• Kicks
• Slaps	• Beatings
Psychological abuse	
• Constant belittling	• Physical and social isolation
• Intimidation	• Monitoring of movements
• Humiliation	• Restricting access to resources
• Controlling behavior	
Sexual abuse	
• Coercive sex	

Adapted from Heise and colleagues[1]

As noted, intimate partner violence extends beyond physically violent acts and may include emotional, psychological, or sexual abuse. Although intimate partner violence is defined as a pattern of behaviors, a single violent act may also be considered intimate partner violence since that one act is often a precursor to repeated violent episodes. Accordingly, the earlier intimate partner violence is detected and addressed, the greater the chance of preventing further abuse. (In the case study, Sarah showed no signs of physical trauma. Instead, Sarah's abuse was manifested in the form of verbal insults, isolation from friends and family, and restriction of access to resources.)

Another important element of some abusive relationships is that the violence is episodic, with acute occurrences interspersed with periods in which no abusive events take place. In these cases, the abuser often apologizes profusely for specific behaviors and promises never again to engage in similar conduct. This behavior lasts until, for whatever reason, another episode of violence occurs.

Although most research on this issue has examined the female partners of male abusers, males can also be abused by their female partners. Intimate partner violence occurs in gay and lesbian relationships as well. In clinical practice, physicians should be aware of these possibilities and, as always, treat these cases in a sensitive and nonjudgmental manner.

Who is at risk? Intimate partner violence is far more common than most people, including physicians, care to admit. No group is immune from intimate partner violence. Its victims include men and women, young and elderly, wealthy and poor, every profession and level of education, and every racial and ethnic group.

Approximately 85% of victims of intimate partner violence are females, most of whom are victimized by male partners, while 15% of victims are males, most of whom are abused by female partners.[2] Data on male victims are particularly scarce, but among women, research suggests that certain groups are more likely to be victimized than others.[3] However, in order to detect intimate partner violence, physicians should be alert to the possibility of abuse in all patients.

Women more likely to be victimized

- Women who are single, separated, or divorced (or are planning a separation or divorce)
- Women between the ages of 17 and 28
- Women who abuse alcohol or other drugs or whose partners do
- Women who are pregnant may be at increased risk

Why victims do not leave A common question is "Why doesn't the victim just leave?" While seemingly an obvious solution to the problem, the question ignores the dynamics of intimate relationships. Victims may not leave because:

- The abuser may display the behavior only in limited circumstances, such as when intoxicated by alcohol or other drugs.
- The abuse is cyclic, with periods in which the abusive partner is a "model partner," expressing regret for the abuse and promising that similar incidents will never happen again.
- Most often, the victim is simply interested in seeking an end to the abuse, not an end to the relationship.
- In particularly harsh cases, the victim may have access to so few resources or be so fully controlled that exiting the situation would require extended, careful planning, and might not be feasible at all.
- The victim is fearful—in cases involving violence, the victim's life may be endangered. For women in violent relationships, the time of greatest danger is when she is attempting to leave the relationship. In some cases, the partner explicitly threatens violence if the victim attempts to leave.

Epidemiology of intimate partner violence

The incidence and nature of intimate partner violence in this country are matters of some controversy. Despite the controversies, the incidence of intimate partner violence is sufficiently great that virtually all physicians, particularly primary care physicians, are likely to encounter cases among their patients. In addition, close to 17% of people treated in emergency departments in 1994 were treated for injuries resulting from intimate partner violence.[4]

Moreover, the prevalence of victimization, whether by intimate partner violence or other forms of abuse, is far higher among clinical populations than among the general public. The data below reflect statistics on physical violence. Data on other types of intimate partner violence have not generally been collected; therefore, gauging the extent of psychological abuse or other types of abuse is not possible.

Data on women Data on the incidence of intimate partner violence against women suggests that between 671,000 and 1.8 million women are physically assaulted annually.

- The 1985 National Family Violence Survey (NFVS)[5] reported that some 1.8 million women in the United States were beaten by their partners annually.
- The National Violence Against Women Survey (NVAWS)[2], carried out during 1995-1996, suggests that 1.3 million women suffer physical assaults and 200,000 are raped by an intimate partner (a current or former husband, cohabiting partner, or date) annually.
- The National Crime Victimization Survey (NCVS)[6] indicates that about 671,000 women were victimized by intimate partners in 1999, a rate of about six per 1,000 women aged 12 years or older. That figure is nearly 40% lower than the 1993 statistic of 1.1 million.

Data on men Both qualitative and quantitative differences exist in comparing men and women as victims of intimate partner violence.

- The NFVS[5] reports that rates of intimate partner assault in married and cohabiting couples are about the same for men and women. Thus, these data would suggest that in the mid-1980s, well over a million men were struck by their female partners.
- In the NVAWS[2], parallel data were collected for men and women specifically to facilitate comparisons. The results indicate that about 835,000 men were physically assaulted by an intimate partner in the survey period (1995-1996). For men, physical assaults were less likely to be the result of intimate partner violence.
- The NCVS[6] also suggests that men were less likely to be victims of intimate partner violence. The 1999 survey found about 120,000 cases of intimate partner violence directed against men. Like women, about two thirds of the cases of intimate partner violence against men were simple assaults. Most of the remaining cases of intimate partner violence against men were aggravated assaults. Women, on the other hand, were at substantial risk of rape and robbery by their intimate partners. The overall rate of intimate partner violence for men was about 1.2 cases per 1,000, which was about one-fifth the rate for women.

Physical injuries in women and men According to data from NVAWS, women are more than twice as likely as men to report being injured in assaults by

intimates: 41% to 19%.[2] Men's greater average strength probably accounts for some of this difference. Data from the NCVS present a similar picture, with half of female victims of intimate partner violence reporting injuries compared to one third of male victims.[6] This is all the more remarkable because the survey reports that about two thirds of both male and female victims of intimate partner violence were physically attacked. Thus, women are much more likely to report injuries.

While most injuries are relatively minor, involving bruises and scratches, more serious injuries can occur. Serious injuries such as knife wounds, internal injuries, broken bones, and loss of consciousness are found in about one in 20 victims of intimate partner violence, male or female.[6] It has long been established that female victims of intimate partner violence are far more likely to sustain an injury to the breast, chest, or abdomen than victims of unintentional injuries. Long-term, chronic conditions may also be associated with abuse by intimate partners, and the mental health effects of such violence may be particularly devastating.

Data on same-sex relationships Given the sensitive nature of the issue and the fact that partners in same-sex relationships are often subject to discrimination, data on intimate partner violence in same-sex relationships are quite limited. It is generally believed that intimate partner violence is at least as prevalent among homosexual couples—male or female—as among heterosexual couples.

Some data suggest that the prevalence of intimate partner violence may vary by gender of the couples. Tjaden and colleagues, using data from a national telephone survey, compared the lifetime prevalence of violence in same-sex and opposite-sex cohabiting couples. They report that respondents with same-sex intimate partners were more likely than respondents in opposite-sex relationships to have experienced violence of all types, including physical assaults by their intimate partners.[2] Their study also found a higher prevalence of intimate partner violence among same-sex cohabiting males compared with opposite-sex cohabiting couples, while the opposite was true for same-sex cohabiting female couples. The NCVS paints a similar picture, estimating that between 1993 and 1999, an average of 10% of intimate partner victimizations involved male partners, while the corresponding figure for female partners was only 2%.[6]

Instances of intimate partner violence in same-sex couples share additional similarities with cases in heterosexual couples. The violence frequently escalates over time, and the victim will often remain in the relationship despite ongoing abuse. More importantly, the reasons underlying the abuse parallel the reasons for the abuse in other relationships: one partner is trying to exert power and control over the other.

Data on teen dating relationships Over the past decade there has been growing interest in levels of violence among adolescents in dating relationships, in part because of general concerns about youth violence but also because studies have found that the likelihood of intimate partner violence is inversely related to age. Silverman and colleagues[7] report that one in five adolescent girls is physically or sexually abused by a dating partner and Sege and colleagues[8] report that nearly one in ten intentional injuries to adolescent girls is inflicted by a male dating partner. The long-term consequences of such violence and abuse are not known, but Silverman and colleagues report links between this abuse and substance use, unhealthy weight control, sexual risk behavior and pregnancy, and suicidality for adolescent girls.[7] Adolescents who are involved in same-sex relationships may be at even greater risk for experiencing violence in their relationships.

Intimate partner homicide Murder by an intimate partner is a rare event for both men and women. However, women are far more likely than men to be murdered by an intimate partner, 0.8 cases per 100,000 women and 0.5 cases per 100,000 men. In this most extreme form of interpersonal violence, 1,218 women were murdered by their intimate partners in 1999. At the same time, intimate partner homicide made up only 4% of the murders of men (424 in 1999) but fully one-third of the murders of women.[6] This pattern has held for several years and is true across all types of violence as reported in the NCVS: women are more likely to be victimized by a nonstranger—a friend, family member, or intimate partner—than men, who are more likely to experience violence at the hands of a stranger.

Pregnancy and intimate partner violence

There is some controversy about the extent of violence during pregnancy. Prevalence estimates range from about 1% to nearly 20% and some authorities argue that pregnancy and the post-partum period are particularly risky times. Irrespective of its prevalence, the key point is that pregnancy and the post-partum period do not preclude intimate partner violence. In fact, in some instances, intimate partner violence may actually begin

during pregnancy. There is also evidence to suggest that abused pregnant women are more likely than non-abused women to delay prenatal care, and that pregnant teens may be particularly likely to experience abuse.[9] In addition, any abuse that continues during pregnancy may endanger the health of both the mother and fetus, and lead to poor fetal outcomes.

Children witnessing intimate partner violence

Children raised in violent homes may be at increased risk for perpetrating or experiencing violence in adulthood. However, note that not all abusers or their partners were exposed to family violence while growing up. Available data indicate that children under the age of 12 reside in 43% of the homes in which intimate partner violence occurs;[6] therefore, many young children are likely to witness their parents engaging in physical violence. In fact, the NFVS data suggest that between 1.5 and 3.3 million children witness intimate partner assaults each year.[5]

More importantly, intimate partner violence and child abuse can occur concurrently, and it is likely that those who are abusive of their intimate partners are likely to abuse children of intimate partners as well. Child abuse has been reported to occur in one third to one half of families in which intimate partner violence occurs.[3]

The preponderance of evidence shows that children exposed to such violence are encumbered in a number of ways. These children tend to exhibit more aggression and other behavioral problems; more mental health difficulties including depression, anxiety, and suicide; and more difficulty in schoolwork.[10] Felitti and colleagues report that the greater the household dysfunction, the greater the child's likelihood of exhibiting health risk factors such as substance abuse, smoking, depression, and suicide attempts in the long term.[11]

Sexual assault and intimate partner violence

Physicians must also be aware that many patients are sexually assaulted as an element of intimate partner violence. That is, intimate partner violence and sexual assault often occur together, and the patient is forced to deal with dual trauma. By acknowledging the intersection of crimes involving interpersonal violence—including intimate partner violence, sexual assault, marital and date rape, and stalking—comprehensive and non-fragmented care can be provided.

Because there are certain medical, emotional, and legal issues that must be addressed in the care of sexual assault victims, their medical treatment is highly specialized. Hospital emergency department personnel must be appropriately trained in order to provide effective and immediate interventions for rape victims, including marital rape. In addition, pregnancy prophylaxis, HIV and Hepatitis B testing and other needs must be addressed. The involvement of rape counselors and companion counselors allows for effective interventions by physicians and other health care workers that integrate the advocacy community with vital medical services.

Racial and ethnic health disparities

Health disparity refers to "…differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[12] Recent data suggest that racial and ethnic disparities exist in the prevalence of intimate partner violence. The NCVS data indicate that black women experienced higher rates of intimate partner violence than white women. The survey found that, on average, approximately 12 per 1,000 black women aged 12 or older experienced nonlethal violence at the hands of an intimate partner between 1992 and 1996. In comparison, white females experienced intimate partner violence at an average rate of 8 per 1,000 during this same time period.[6]

NVAWS data (Table 1) also finds disparities in the rates of intimate partner violence among different racial groups. In total, American Indian/Alaska Native women and men, had the highest rates of intimate partner victimization, 37.5 and 12.4 respectively.[2] The NVAWS found Asian/Pacific Islander women and men to have the lowest rates of victimization. However, it is unclear whether the differences in rates of intimate partner violence among different racial groups can be explained by socioeconomic, environmental or cultural factors, or differences in the reporting of abuse.

Since intimate partner violence is found at some level in all racial groups, physicians should be alert to the signs of intimate partner violence in all of their patients.

Cultural issues

A physician's office, clinic, or hospital may serve a culturally diverse community. Before performing the clinical evaluation, physicians should be aware of the role that culture plays in the health beliefs and behaviors of the patient experiencing intimate partner violence. While intimate partner violence cuts across all racial, ethnic, religious, educational, and socioeconomic lines, cultural background may influence a victim's attitudes toward abuse and their access to care.

Table 1
Lifetime victimization by an intimate partner (%) by type of victimization, victim gender and race
Source: Adapted from Tjaden and Thoennes[2]

	White	African-American	Asian/ Pacific Islander	American Indian/ Alaska Native	Mixed Race
Women					
Type of victimization	(n=6,452)	(n=780)	(n=133)	(n=88)	(n=397)
Rape	7.7	7.4	3.8	15.9	8.1
Physical assault	21.3	26.3	12.8	30.7	27.0
Stalking	4.7	4.2	—[a]	10.2	6.3
Men					
Type of victimization	(n=6,424)	(n=659)	(n=165)	(n=105)	(n=406)
Rape	0.2	0.9	—[a]	—[a]	—[a]
Physical assault	7.2	10.8	—[a]	11.4	8.6
Stalking	0.6	1.1	—[a]	—[a]	1.2

[a] Estimates not calculated on fewer than five victims.

For physicians, developing cultural competence skills is an effective response to the major demographic changes that are occurring among the population, and plays an integral role in reducing health disparities.

Cultural competence

A set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communications patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups.[13]

Physicians and their staff, in collaboration with community organizations and advocates, should ensure that all patients receive culturally and linguistically effective care and services.

Cultural competence tips for physicians

- Get to know your patients. This will help you gain an understanding and appreciation for the cultural factors that shape their health beliefs and behaviors.
- Respect the cultural differences of your patients.
- Hire staff that reflects the patient population.
- Train bilingual staff in interpreter skills or employ professional interpretation services.
- Do not allow a non-staff member to provide interpretation. This is necessary in order to ensure confidentiality and safety for the victim of intimate partner violence.
- Provide multilingual patient education materials. These materials should include patient awareness brochures about intimate partner violence and information on community resources such as victim advocates, social services, shelters, etc.
- Place multilingual posters in patient areas and restrooms that indicate physicians and staff members are willing to listen and help in cases of intimate partner violence.
- Establish literacy programs within the health clinic or center, or refer patients to community organizations that offer such programs.

These are just some of the ways that physicians, health care professionals, and other staff members can deliver culturally and linguistically effective health care. Because there is no fixed formula for achieving cultural competence in a health care environment, health care professionals should strive to involve the community's organizations and leaders in defining and addressing the health needs of the community. Strong partnerships among physicians, community organizations, and advocates involved in issues of intimate partner violence will improve access and quality of care for victims of abuse and help eliminate health disparities.

Clinical evaluation

Although many cases of intimate partner violence do not present in a standard, straightforward manner, the process of diagnosing intimate partner violence through a careful History and Physical, of documenting all evidence appropriately, and of offering health interventions remains the same from case to case. In this section, we will provide practical information and guidance on this process. Because intimate partner violence is as likely to occur in gay and lesbian couples as in heterosexual couples, the physician must be open to finding intimate partner violence in all patients.

Signs and symptoms of intimate partner violence

Because many of the signs and symptoms of intimate partner violence are neither sensitive nor specific, the formulation of a diagnosis requires careful consideration of the patient's presenting complaints and presentation, as well as appropriate and sensitive inquiries. In cases in which the patient purposely tries to mask the diagnosis, clinical vigilance is crucial. (In the case study, Sarah did not present with complaints about abuse but the physician's inquiries led Sarah to admit experiencing intimate partner violence at the hands of her husband.)

It is often a constellation of signs or a recurring pattern of health care utilization or help-seeking that lead to the diagnosis of current or past intimate partner violence. Signs and symptoms that should alert the physician include:

Injury Episodes of physical assault characterize abusive relationships. Physicians should especially consider the possibility of assault when the explanation for an injury does not seem plausible or when there has been a delay in seeking medical care. Common types of injury include:

- Contusions, abrasions, and minor lacerations
- Fractures or sprains
- Injuries to the head, neck, chest, breasts, and abdomen
- Injuries during pregnancy
- Multiple sites of injury
- Repeated or chronic injuries

Medical findings The stress of living in an ongoing abusive relationship may cause any of the following:

- Chronic pain, psychogenic pain
- Physical symptoms related to stress, post-traumatic stress disorder, other anxiety disorders, or depression. These may be manifested through such physical symptoms as:
    - Sleep and appetite disturbances
    - Fatigue, decreased concentration, sexual dysfunction
    - Chronic headaches
    - Abdominal and gastrointestinal complaints
    - Palpitations, dizziness, paresthesias, dyspnea
    - Atypical chest pain
- Psychiatric symptoms related to stress, post-traumatic stress disorder, other anxiety disorders, or depression, including:
    - Feelings of isolation and an inability to cope
    - Suicidal attempts or gestures
    - Alcohol or drug abuse
- Frequent use of prescribed minor tranquilizers or pain medications
- Frequent clinic visits with vague complaints or symptoms without evidence of physiologic abnormality
- Multiple ED visits

(In the case study, Sarah presented with sleep and appetite disturbances. If her doctor had not been aware that these are signs of possible intimate partner violence, the abuse might not have been discovered.)

Note that routine assessment of intimate partner violence in the patient's family is important for both men and women in alcohol and drug rehabilitation programs. Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their addicted partners.[3]

Behavioral signs The stress of ongoing abuse may lead patients to appear frightened, ashamed, evasive, or embarrassed. Not uncommonly, the victim may believe he/she deserves the abuse because the abuser tells the patient so. He/she may even take responsibility for the partner's violence to maintain some sense of control over the situation. Other findings may include the following:

- Partner accompanies patient, insists on remaining in the exam room, and answers all questions directed at the patient
- Patient's reluctance to speak or disagree in the presence of the partner
- Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- Denial or minimization of violence by partner or by patient
- Patient's exaggerated sense of personal responsibility for the relationship, including self-blame for the partner's violence

A number of other clues may result from an abusive partner's controlling behaviors within a violent relationship. For example, the abused partner may:

- Have limited access to medical care for either routine or emergency situations
- Miss appointments or exhibit noncompliance with treatment regimens
- Not be allowed to obtain or take medication
- Lack independent transportation, access to finances, or the ability to communicate by phone
- Not be informed of the partner's infections, including HIV and other sexually transmitted diseases, or report that the partner refuses to use condoms or other contraceptive methods

Gynecologic and obstetric issues Sexual coercion and assault are common expressions of intimate partner violence inflicted on women. Assessment for sexual abuse and rape should be addressed in the sexual or social history taken during routine primary care visits, in discussions of birth control and safer sexual practices, and during gynecologic and obstetric visits.

Recent evidence has found both pregnancy and the postpartum period to be particularly risky times for women, with as many as 20% of pregnancy-associated deaths being homicides.[14] Because of the risk to the mother and fetus, assessment for abuse should be incorporated into routine prenatal and postpartum care.

Gynecologic and obstetric presentation of intimate partner violence include:

- Frequent, unexplained gynecologic complaints
- Frequent vaginal and urinary tract infections
- Dyspareunia or pelvic pain
- Injuries to the breasts, abdomen, and genital area
- Substance abuse, poor nutrition, depression, and late or sporadic access to prenatal care during pregnancy
- History of "spontaneous" abortions, miscarriages, and premature labor

Routine screening

Intimate partner violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Because some women may not initially recognize themselves as "abused," the physician should routinely ask direct, specific questions about abuse. Such questions may be included as part of the social history, past medical history, review of systems, or history of present illness, as appropriate. However, the Family Violence Prevention Fund (FVPF) recommends that providers pursue training and assistance on these skills prior to implementing screening. Model training materials, departmental guidelines, protocols and other tools are available through the FVPF's toll free number **888 Rx-ABUSE (888 792-2873**) and many other organizations.

Screening for intimate partner violence

The US Preventive Services Task Force develops evidence-based recommendations to guide a physician's clinical decisions regarding preventive services. Regarding intimate partner violence, the Task Force makes the following recommendations:[15]

- Including a few direct questions about abuse as part of the routine history in adult patients may be recommended due to the substantial prevalence of undetected abuse.
- Suspected cases of abuse should receive proper documentation of the incident and physical findings (eg, photographs, body maps); treatment of physical injuries; arrangements for counseling by a skilled mental health professional; and the telephone numbers of local crisis centers, shelters, and protective service agencies. The safety of children of victims of abuse should also be ensured.

In addition, screening for intimate partner violence among female patients is recommended by several medical specialty societies or related health care groups, including:

- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Emergency Physicians
- American College of Nurse Midwives
- American College of Obstetrics and Gynecology
- American Dental Association
- American Medical Association
- Emergency Nurses Association
- Joint Commission on Accreditation of Healthcare Organizations

Some of these policies are written to clearly apply to both male and female patients.

Experts suggest that providers should be knowledgeable of local resources and prepared for a positive response before undertaking routine screening of their patients.

Although patients may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions in a nonjudgmental manner and in a confidential setting. The patient should be interviewed alone, with no partner present. The physician should make a supportive opening statement, such as: "Because abuse and violence are so common, I've begun to ask about it routinely." Even if the patient does not respond at the time, the fact that a physician is concerned about abuse will make an impression. This concern validates the patient's feelings and may reinforce his/her motivation to seek intervention. Questions about intimate partner violence should be asked in the physician's own words and in a nonjudgmental way. (In the case study, Sarah only admitted and discussed her experience with intimate partner violence after the physician, alert to the signs of abuse, questioned her about her sleep and appetite disturbances.)

Examples of recommended questions:

- Are you in a relationship in which you have been physically hurt or threatened by your partner? Have you ever been in such a relationship?
- Are you (have you ever been) in a relationship in which you felt you were treated badly? In what ways?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to or forced you to engage in sex that makes you feel uncomfortable?
- We all fight at home. What happens when you and your partner fight or disagree?
- Do you ever feel afraid of your partner?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- You mentioned that your partner uses drugs/alcohol. Is the abusive behavior more or less likely, or more or less severe, when your partner is using drugs or alcohol?
- Do you have guns in your home? Has your partner ever threatened to use them against you?

Taking the abuse victim's history

If it is determined that the patient is the victim of intimate partner violence, the patient's history should include a description of the abusive event(s), using the patient's own words whenever possible. This description should also include an account of any injuries, how the injuries were inflicted, what precipitated the events, when and where they took place, and who was present. It is also useful to document whether this has occurred in the past and, if so, when and how frequently.

In addition to the information above, the physician should have knowledge of the patient's current safety status and scope of the problem. Understanding the patient's situation will aid the physician in creating an assessment and plan. The questions to the right may be helpful in eliciting this information.

Routine questions about violence not only identify those who are currently being abused, but also serve to assess the safety of patients who have been abused in the past. Routine assessment is particularly important for those who have just left a violent relationship as leaving an abusive partner or finalizing a divorce may increase a person's risk for abuse. In these cases, the physician should assess the patient's need for an emergency shelter or other resources.

A medical encounter may provide the only opportunity to stop the cycle of violence before more serious injuries occur. Providing the patient with a different kind of experience—one in which the patient is taken seriously and treated with respect; one that acknowledges the patient's right to be free from abuse; one that offers the possibility of support and safety; and one that encourages the patient's choices and decision making—is in itself therapeutic and an important step.

Understanding the patient's situation

The answers to these questions may suggest (or even dictate) certain courses of action

Safety

- Do you currently feel safe at home? If not, why?
- Does your partner have immediate and easy access to any type of gun or other weapon (eg, hunting knife) in the home?

Extent of problem

- In addition to current physical and emotional abuse, does your partner abuse you in any other way? Does your partner abuse you sexually? Deprive you of money? Prevent you from going out, making phone calls, or seeing your family and friends?
- Are you experiencing any other problems such as post traumatic stress disorder (screen for PTSD), suicidal thoughts, alcohol or drug use?

Safety of others in the household

- Is anyone else in the household being abused in any manner by your partner? Children? Parents, aunts, uncles, etc.?

Other witnesses

- Has anyone else witnessed your partner's behavior?

Resources

- Are there community resources available to you, such as telephone hotlines or shelters for abused women or men? Have you tried to use them in the past? If so, what happened?
- Do you have any friends or family in the area that would help you in the event of an emergency?

Planning

- Do you have an immediate need for family shelter services, an attorney, or an order of protection?
- What is your readiness for change? Have you ever thought about leaving the relationship? Do you think that you are ever likely to leave the relationship?
- Have you worked out an escape or safety plan in the event of a future emergency?

Documentation of intimate partner violence

Thorough, well-documented medical records are essential because they provide concrete evidence of violence and abuse and may prove crucial to the outcome of a legal proceeding. If the medical record and testimony at trial are in conflict, the medical record may be given more credibility, especially if it has been maintained in a precise, professional, and confidential manner. The Summary Action Plan elements at the beginning of this booklet should all be addressed and documented in the medical record.

In addition to complete written records that address the elements in the Summary Action Plan, photographs are particularly valuable as evidence. For this reason, it is a good idea to keep an instant camera in the ED or clinic. Prior to taking any photographs, the physician should secure the patient's permission. In addition, patients may feel more comfortable if someone of the same gender takes the photographs.

In photographing injuries, the following guidelines should be followed as closely as possible:

- Whenever possible, take photographs before medical treatment is given.
- Use color film, along with a color standard.
- Photograph from different angles, full body and close-up.
- Hold a coin, ruler, or other object next to the injury to illustrate its size.
- Include the patient's face in at least one photograph.
- Take at least two pictures of every major trauma area.
- In at least one photograph, have the patient hold up a card with his/her name and the date.
- As soon as possible, mark photographs precisely with the patient's name, location of injury, date of ED/clinic visit, and names of the photographer and others present.

Depending on the type of injury, imaging studies (eg, x-rays for fractures, head CT for traumatic brain injuries) may also be useful. State laws that apply to the taking of photographs usually apply to x-rays as well.

For medical records to be admissible in court, the doctor should be prepared to testify:

- That the records were made during the "regular course of business" at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- That the records have been properly stored and their access limited to professional staff

Treatment and intervention

Once abuse is recognized, a number of interventions are possible:

- At the very least, even if a patient is not ready to leave the relationship or take other action, the physician's recognition and validation of the situation is important. Silence, disregard, or lack of interest convey tacit approval or acceptance of intimate partner violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it. The physician should listen to the patient and provide validating messages. The patient should receive constant reassurance that the abuse is not his/her fault.
- If the patient is not ready to leave the relationship or take other action, he/she should be encouraged to visit the clinic or ED for future episodes of abuse, not only for treatment but for the purpose of documentation. By leaving a "paper trail," the patient is armed with evidence in the event that he/she decides to take legal action against the abuser.
- The injury or complaint that precipitated the health care encounter requires evaluation and appropriate treatment. In addition, the physician should ask about the patient's use of pain, sleeping, or antianxiety agents. Psychiatric problems, including severe depression, panic disorder, suicidal tendencies or substance abuse, may hinder the victim's ability to assess the situation or take appropriate action. When serious psychiatric conditions are present, an appropriate treatment plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral, and cognitive symptoms of abuse can be misinterpreted as psychiatric in origin. Physicians must ensure that the mental health professional to whom they refer the patient is sensitive to these issues.
- Alcohol or drugs may be used to rationalize violent behavior. Evidence indicates that while substance abuse and violent behavior frequently coexist, the violent behavior will not end unless interventions address the violence as well as the addiction. Similarly, mental illness is rarely the cause of intimate partner violence, although mental illness in an abuser can lead to loss of control and increased frequency and severity of violence. Treating the mental illness alone will not end the violence. Both issues must be addressed, and the abuse victim should understand that alcohol, drugs, or mental illness are not excuses for, nor causes of, abuse.
- Couples' counseling or family intervention is generally contraindicated in the presence of intimate partner violence. Attempts to implement family therapy in the presence of ongoing violence may increase the risk of serious harm. *The first concern must be for the safety of the patient and children.*
- In situations in which children are also being abused, coordinated liaisons between advocates for victims of domestic violence and child protective service agents should be used to ensure the safety of all parties. Otherwise, the reporting and investigations of alleged child abuse may increase the patient's risk of abuse. In some jurisdictions, allegations of child abuse can affect the custodial rights of the victim, and this can be another source of frustration and stress.
- Provide information about intimate partner violence to the patient. Intimate partner violence is a health issue for patients and their children. Violence can escalate but stopping intimate partner violence is the responsibility of the perpetrator, not the victim. A patient should receive information regarding support that is available within the health system and legal options, and be given referrals to local community resources including victim advocacy services.

- Assess a patient's current level of safety. Support victims in protecting themselves and their children by validating their experiences and providing support and information about resources/options. Encourage victims to make their own safety plan (see below) for when a perpetrator is present in the medical setting, when a victim fears leaving the medical setting, or if a victim is returning to the batterer.

Safety planning as an intervention*

Once a patient has been identified as a victim of intimate partner violence, an evaluation of the patient's safety is in order *before the patient leaves the medical setting.* For example, are there immediate safety needs?

- Is the patient in immediate danger?
- Where is the perpetrator now?
- Where will the perpetrator be when the patient is finished with the medical care?
- Does the patient want or need the police or security to be notified immediately?

However, the patient's immediate safety needs are not the only concern. The patient's future safety also requires consideration. That is, is there future risk of death or significant injury or harm due to intimate partner violence?

- Ask about the perpetrator's tactics: use of weapons, escalation in frequency or severity of the violence, hostage-taking or stalking, threats of homicide or suicide, or use of alcohol or drugs. Also ask about the health consequences of past abuse.
- If there are children, inquire about the children's physical safety.

Some victims of intimate partner violence may well solicit the physician's help with safety planning, particularly as intimate partner violence can be expected to increase in frequency and severity over time. If the patient expresses a desire for help with this aspect, particularly if referrals to appropriate agencies are not possible, the physician may need to provide assistance. However, safety planning cannot be rushed. If a physician feels he/she may not have adequate time to help a patient establish a safety plan, other staff members should be trained to conduct the safety planning procedure with the patient.

Most data on this issue concern women and, for that reason, this section refers to the experiences of women patients. Nonetheless, most of these elements would likely apply to situations in which the patient is a male or in which the intimate parties are of the same sex. For an abused woman in a heterosexual relationship, the danger of extreme violence, particularly homicide, is statistically greatest when she is implementing a decision to leave her abuser.

Assisting the patient in making a safety plan can help a victim think through various options, and help the clinician assess the situation and provide better support. The following checklist will help initiate these important discussions.

1. If patient is planning to leave:

- Do you have a friend or supportive family member that lives nearby with whom you can stay?
- Do you want to go to a shelter for battered women, a homeless shelter or use other housing assistance programs such as hotel vouchers from social services or advocacy programs? If none are available, do you want to be admitted to the hospital?
- Do you want to call the police or obtain an order of protection/emergency protective order?
- If you feel you don't need immediate access to a shelter, I am going to provide you with written information about shelters and other resources only if it is safe to do so.

2. If patient is not planning to leave:

- Do you want to return to your partner and schedule a follow-up appointment for a later date?
- Will you call the police if the perpetrator becomes violent? If you cannot get to the phone, could you work out a signal with a neighbor to call the police and/or teach your children to call 911?
- What kinds of strategies have worked in the past to minimize injuries? Do you think these strategies would continue to work for you?
- Can you anticipate an escalation of violence and take any precautions?
- Do you have a support network of friends or family that live nearby who could help when you need assistance?
- Do you need immediate medical attention, psychiatric intervention, or counseling to help deal with the stress caused by the abuse?
- Are there weapons in the home? Can they be removed or placed in a safe locked area separate from the ammunition?

* This section borrows heavily from the work of the Family Violence Prevention Fund (FVPF), and we are grateful for its support in this endeavor. Health care professionals with questions about family violence can contact the FVPF at **http://endabuse.org** or **1 800 RxAbuse.**

3. If the perpetrator has been removed from the home:

- Have you thought about changing the locks on the doors and windows; installing a security system, rope ladders, outdoor lighting sensitive to movement, smoke detectors and a fire extinguisher? Is it financially feasible?
- I encourage you to teach your children how to use the phone and make collect calls in case the perpetrator kidnaps them. Make arrangements with schools and daycare centers to release children only to designated persons.
- I encourage you to tell your neighbors, family and friends that the perpetrator has left and to call 911 if he/she is seen around the house.

4. Being prepared to get away, discuss the following components of a safety plan:

- Keep the following in a safe place:
  - House and car keys
  - Important papers: social security cards and birth certificates (for parent and children), photo ID/ driver's license, green cards
  - Cash, food stamps, credit cards, checkbooks, etc.
  - Medication for parent and children, children's immunization records
  - Spare set of clothes
  - Important phone numbers and addresses (friends, relatives, police, domestic violence shelter)
  - Loose change to make phone calls from pay phones.
- Pack a change of clothes for yourself and your children, personal care items, extra glasses, etc.
- Identify a safe place for the children: a room with a lock or a neighbor's house where they can go, and reassure them that their job is to stay in that place.
- Arrange a signal with a neighbor to let them know when you need help.
- Contact the local domestic violence program to find out about laws and community resources before they are needed.

Patient information and resources

If the patient feels it is safe to do so, provide *written* information (including phone numbers) on legal options, local counseling and crisis intervention services, shelters, and community resources. In addition, educational materials on intimate partner violence in waiting areas, restrooms, and in examination rooms may help patients identify violence as a personal health problem.

Health literacy

Before providing their patients with written materials, physicians must be alert to issues of health literacy, as it is a major factor that influences the health status of individuals. Health literacy is defined as the ability to read, understand, and act on health care information.[16] An individual's ability to read and comprehend prescription bottles, appointment cards, medicine labels, patient educational brochures, and other health-related materials is vital to improved health status and outcomes. However, data suggest that one-third of English-speaking patients and almost two-thirds of Spanish-speaking patients cannot read and understand basic health-related materials.[17]

There is also data that suggest an association between low literacy and violence. Among adolescents, those with poor reading skills have been associated with more violent behavior, both in terms of criminal acts leading to imprisonment and in terms of self-reported physical fighting, weapon carrying, and victimization. In addition, adolescents (both male and female) with poor reading skills were found to be twice as likely to be both aggressor and victim, and were three times more likely to report having been injured in a fight that required medical intervention than adolescents with grade-appropriate reading skills.[18]

Physicians should communicate with their patients in a simple and straightforward manner to ensure that the vital health information and materials provided are understood by the patient.

Physicians can do the following to ensure patient understanding of medical information:

- Provide culturally and linguistically appropriate, plain-language health information.
- Provide medical advice that is simple and easy to understand.
- Review written and oral instructions with all patients.
- Provide instructions and then have the patient demonstrate their understanding by asking the patient to "teach back". For example, in a case of intimate partner violence, a physician can provide information on safety planning (see page 16) and then have the patient repeat what he/she will do to carry out a safety plan.

National organizations on domestic violence and many local and state battered women's programs have information available for use in physician offices.

- The National Domestic Violence hotline **800 799-SAFE (7233), 800 787-3224 (TDD)** is a 24-hour resource to help women find local shelters. Counselors speak Spanish as well as English.
- The Family Violence Prevention Fund **(415 252-8900; www.endabuse.org/health)** provides technical assistance and resource materials to health care providers and policy makers on improving the health care response to domestic violence. (More are listed in the Intimate Partner Violence Resources section on page 21)

Local domestic violence shelters and statewide domestic violence programs are frequently listed in the phone book. They can help with housing, information about

legal rights, welfare applications, and counseling (including peer groups and counseling for children). They may have brochures that address issues and list local resources. Many programs offer these services without charge.

Among men, societal expectations will create both real and perceived barriers to care; for example, there are virtually no shelters specifically for battered men.

- Some information is available by calling the National Domestic Violence Hotline **800 799-SAFE (7233), 800 787-3224 (TDD).**
- Additional information for men in particular may be available from SAFE (Stop Abuse for Everyone), which has a Web site where male victims (straight and gay) and lesbian women can share their stories with others. The Web site address is **www.safe4all.org.** The organization can be contacted at **SAFE, PO Box 951, Tualatin, Oregon 97062.**

SAFE's Web site lists services that are sympathetic to these underserved populations, as well as a number of highly qualified professionals ready to provide training to law enforcement, health-care providers, social service, crisis lines and others, on how to identify, support, and properly refer male victims of domestic violence. SAFE also provides a brochure for male victims and their concerned family and friends.

State-by-state reporting requirements

All states have some type of statute that requires physicians to report to law enforcement officials certain injuries that appear to have resulted from a criminal act. However, physicians may not be aware of these state statutes that mandate such reporting. Below is a list of state-by-state reporting requirements.*

Disclosure of a diagnosis of abuse to any third party and reporting to authorities should be done only with the abused person's knowledge and consent.

Current information on state laws is available as a health report card at: **http://endabuse.org/programs/healthcare.**

State	Injuries from weapons	Injuries from crimes	Injuries from domestic violence
Alabama	No	No	No
Alaska	Yes	Yes	No
Arizona	Yes	Yes	No
Arkansas	Yes	No	No
California	Yes	Yes	Yes
Colorado	Yes	Yes	Yes
Connecticut	Yes	No	No
Delaware	Yes	No	No
District of Columbia	Yes	No	No
Florida	Yes	Yes	No
Georgia	No	Yes	No
Hawaii	Yes	Yes	No
Idaho	Yes	Yes	No
Illinois	Yes	Yes	No
Indiana	Yes	No	No
Iowa	Yes	Yes	No
Kansas	Yes	No	No
Kentucky	No	Yes	Yes
Louisiana	Yes	No	No
Maine	Yes	No	No
Maryland	Yes	No	No
Massachusetts	Yes	No	No
Michigan	Yes	Yes	No
Minnesota	Yes	No	No
Mississippi	Yes	No	Yes
Missouri	Yes	Yes	No
Montana	Yes	No	No
Nebraska	No	Yes	No
Nevada	Yes	No	No
New Hampshire	Yes	Yes	No
New Jersey	Yes	No	No
New Mexico	No	No	No
New York	Yes	No	No
North Carolina	Yes	Yes	No
North Dakota	Yes	Yes	No
Ohio	Yes	Yes	Yes
Oklahoma	No	Yes	No
Oregon	Yes	No	No
Pennsylvania	Yes	Yes	No
Rhode Island	Yes	No	Yes
South Carolina	No	No	No
South Dakota	Yes	No	No
Tennessee	Yes	Yes	Voluntary
Texas	Yes	No	Yes
Utah	Yes	Yes	No
Vermont	Yes	No	No
Virginia	Yes	No	No
Washington	No	No	No
West Virginia	Yes	No	No
Wisconsin	Yes	Yes	No
Wyoming	No	No	No

*Adapted from: Houry D, Sachs CJ, Feldhaus KM, Linden J. Violence-inflicted injuries: reporting laws in the fifty states. Ann Emerg Med. 2002;39:56-60.19

For a more complete discussion, please refer to full article.

Intimate partner violence resources

American Bar Association Commission on Domestic Violence
www.abanet.org/domviol/
The American Bar Association Commission on Domestic Violence Web site provides valuable information about a wide range of domestic violence issues and extensive links to other resources and organizations. The website includes listings of ABA policies, training materials, legal briefs, and sample legal forms relevant to domestic violence issues and proceedings. The Web site also provides information about upcoming events and training opportunities.

American College of Obstetricians and Gynecologists
www.acog.org/from_home/departments/dept_web.cfm?recno=17
The American College of Obstetricians and Gynecologists' Violence Against Women website contains information on domestic violence and sexual assaults. The site includes a listing of state coalitions, screening tools, factsheets, materials and conference information. Some of the information is available in both English and Spanish.

American Medical Association
www.ama-assn.org/go/violence
This site offers information about the American Medical Association's violence-related policies and reports, as well as its activities and projects. Links to other organizations are also provided in an effort to bring together information from organizations in many arenas that are working together against violence.

Center for Disease Control: Family and Intimate Violence Prevention
www.cdc.gov/ncipc/dvp/fivp/fivp.htm
This site contains information on surveillance, research, evaluation, communication, and training issues focusing on family and intimate partner violence prevention, and also includes information on funded projects.

Intimate Partner Violence Fact Sheet
www.cdc.gov/ncipc/factsheets/ipvfacts.htm#References
Defines intimate partner violence and provides statistics and information about health effects and prevention.

Family Violence Prevention Fund
http://endabuse.org/
This site focuses on the impact of domestic violence on health care, the workplace, child protection, and immigrant women. Includes information on public education initiatives including the men's campaign, "Teach early." Provides a celebrity watch page that traces celebrity involvement in domestic violence issues.

National Center for Children Exposed to Violence
www.nccev.org/
This site provides information for anyone seeking information about the effects of violence on children and the initiatives designed to address this problem.

National Center for Victims of Crime
www.ncvc.org/
This site includes information for victims and victim service providers such as safety strategies, toll-free helpline, and on-line referral requests. This site also includes Public Policy and Civil Litigation information and a Stalking Resource Center.

National Coalition Against Domestic Violence
www.ncadv.org
This site includes resources, public policy, and community response to domestic violence and information on getting help for victims.

National Domestic Violence Hotline
www.ndvh.org/
This site contains links, information about the hotline services. **800 799-SAFE,** TDD for the hearing impaired: **800 787-3224**

National Women's Health Information Center

www.4woman.gov/violence/index.cfm

The Information Center site includes general resources and information on intimate violence, sexual assault and abuse, dating violence, and elder abuse.

Office of Women's Health

www.4woman.gov/owh/violence.htm

The Office of Women's Health site offers information on the National Advisory Council on Violence Against Women and issues related to family and intimate violence.

Violence Against Women Office

www.ojp.usdoj.gov/vawo/

The US Department of Justice's Violence Against Women Web site provides information on promising practices and model programs for law enforcement practitioners and victim advocates.

Domestic violence abuse assessment

R A D A R

Date _____ Patient ID# _____

Patient name _____

☐ Yes ☐ No Is the patient pregnant?

☐ Yes ☐ No **Abuse confirmed**

If yes, name of alleged perpetrator and relationship to client:

_____

_____

☐ Yes ☐ No **Abuse suspected** State reasons:

_____

_____

_____

_____

R Routinely screen

Because violence is so common in intimate partner relationships, I've begun to ask about it routinely.

A Ask direct questions

☐ Yes ☐ No Do you feel safe at home?

☐ Yes ☐ No Are you in a relationship in which you have been hurt or threatened?

☐ Yes ☐ No Have you ever been hit, kicked, or punched by someone close to you? _____ # of times in past year.

☐ Yes ☐ No Has your partner ever forced you into sex against your wishes?

D Document findings

Use patient's own words to describe assault (She says her boyfriend, John Smith, struck her with fists or object, kicked, thrown, etc.)

_____

_____

_____

A Assess patient safety

☐ Yes ☐ No Is patient afraid to go home?

☐ Yes ☐ No Increase in severity/frequency of abuse?

☐ Yes ☐ No Threats of homicide or suicide?

☐ Yes ☐ No Weapons present?

☐ Yes ☐ No Threats to children and/or pets?

R Respond options and refer

☐ Yes ☐ No Need immediate shelter?

☐ Yes ☐ No Hotline numbers/community resources given?

_____

☐ Yes ☐ No Referred to outside source?

☐ Yes ☐ No Follow-up appointment made? Date _____

☐ Yes ☐ No Can patient be called at home? If no, is there a safe number where client can be reached?

_____

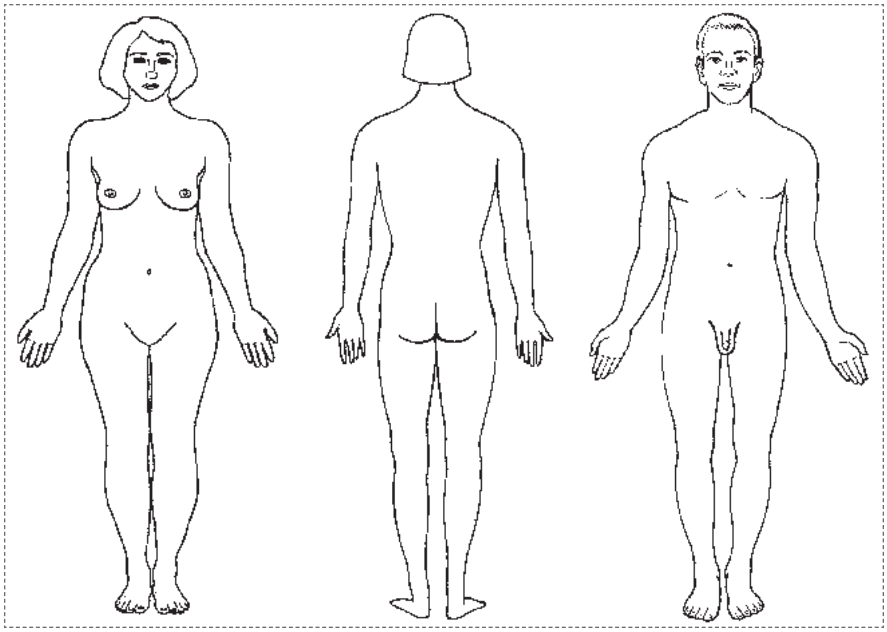
Source: Institute for Safe Families, Philadelphia, PA 215 843-2046

Check physical findings

	Contusion	Abrasion	Laceration	Bleeding	Tenderness
Head					
Eyes					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitals					
Buttocks					
Legs					
Feet					

☐ Yes ☐ No Photographs taken?

Indicate where injury was observed



Provider evaluation

_____

_____

_____

_____

_____

_____

_____

_____

Provider Signature

_____

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Roadmaps for Clinical Practice
Case Studies in Disease Prevention and Health Promotion
Intimate Partner Violence

CME questionnaire

Instructions: The Intimate Partner Violence monograph contains the correct answers to the following questions. Select your answer to each question and write the corresponding answer in the space provided on the answer sheet.

1. The intent of intimate partner violence is for one partner to exert power and control over the other partner.
   a. True b. False
2. Alcohol or drug abuse is a major cause of intimate partner violence.
   a. True b. False
3. The incidence of intimate partner violence is sufficiently great that virtually all physicians are likely to encounter cases among their patients.
   a. True b. False
4. According to statistics, what groups of women may be at higher risk for intimate partner violence?
   a) Women between the ages of 17 and 28
   b) Women between the ages of 30 and 45
   c) Women who are pregnant
   d) a and c
   e) b and c
5. The prevalence of intimate partner violence among same sex intimate couples is less than in opposite sex couples.
   a. True b. False
6. Children raised in homes where intimate partner violence exists are at increased risk of being abused themselves or for perpetuating or experiencing violence in adulthood.
   a. True b. False
7. Batterers are loners who prefer it when their partner has little contact with them.
   a. True b. False
8. Intimate partner violence may be characterized by which of the following:
   a. Repeated battering and injury
   b. Psychological abuse
   c. Sexual assault
   d. Social isolation
   e. All of the above
9. Routine screening for intimate partner violence is a significant strategy to protect a physician from liability.
   a. True b. False
10. Victims of abuse generally respond positively and early to physician's questions in the course of routine screening for intimate partner violence.
    a. True b. False
11. A physician should inquire about intimate or family violence only when a patient presents with obvious physical injuries.
    a. True b. False
12. According to the 1985 National Crime Victimization Survey (NFVS), how many women are beaten by their partners annually?
    a. 8 million
    b. 1.8 million
    c. 1.3 million
    d. 10 million
    e. 800,000
13. Family counseling is an especially helpful technique in situations involving intimate partner violence.
    a. True b. False
14. Male batterers are much less likely to inflict physical damage on their female partner who is pregnant
    a. True b. False
15. The victim of intimate partner violence is rarely if ever to blame for the violence.
    a. True b. False

American Medical Association

Physicians dedicated to the health of America

CME answer sheet

Please complete and mail the form to:

Division of Continuing Physician
Professional Development
American Medical Association
515 North State Street
Chicago, IL 60610

Or, fax the form to: 312 464-4567

For more information, please call: 312 464-4065

Roadmaps for Clinical Practice: Case Studies in Disease Prevention and Health Promotion—Intimate Partner Violence

Exam response

Circle your response, one response per question

Q1	a	b			
Q2	a	b			
Q3	a	b			
Q4	a	b	c	d	e
Q5	a	b			
Q6	a	b			
Q7	a	b			
Q8	a	b	c	d	e
Q9	a	b			
Q10	a	b			
Q11	a	b			
Q12	a	b	c	d	e
Q13	a	b			
Q14	a	b			
Q15	a	b			

Please print and include all information requested

Name _____

Address _____

City _____

State _____ Zip _____

Phone ( ) _____

Fax ( ) _____

E-mail _____

Medical School _____

Year of Graduation _____

Program evaluation

1. This monograph is a useful and effective physician education tool.

Strongly agree 1 2 3 4 5 Strongly disagree

2. The information provided is adequate in addressing the issue of intimate partner violence.

Strongly agree 1 2 3 4 5 Strongly disagree

3. The program met the learning objectives.

Strongly agree 1 2 3 4 5 Strongly disagree

4. I will incorporate this information and use it in my clinical practice.

Strongly agree 1 2 3 4 5 Strongly disagree

5. I will recommend this monograph to my colleagues.

Strongly agree 1 2 3 4 5 Strongly disagree

6. I would like to see similar education programs for other clinical issues..

Strongly agree 1 2 3 4 5 Strongly disagree

American Medical Association

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Case Studies in Disease Prevention and Health Promotion

Intimate Partner Violence

American Medical Association

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